THE HEALTH SERVICES DELIVERY SYSTEM*

EVA M. REESE, R.N.

Executive Director
Visiting Nurse Association of New York
New York N.Y.

IN the time allotted to me, I have chosen to discuss home health care for two main reasons. First, it is the field I think I know a little about; and second, I could be fairly sure of little competition. Home health services are not often in the limelight.

These services did gain some attention in the 1940's, when a few hospitals developed so-called coordinated home care programs. While these programs still are to be found, their growth in numbers, in range of services or in geographic coverage has been somewhat less than phenomenal.

In 1966, with the advent of Medicare and Medicaid, we saw some renewed interest in home health care since it became part of the "covered services." For the first time there seemed to be the promise of a firm source of financing for the development and expansion of health services outside of institutions. Existing agencies in the home health field did indeed expand their ongoing nursing programs, primarily adding home-health-aide services and physical therapy. Some new agencies were organized. Many of these were under proprietary auspices and most often were placed in areas where some home health service already existed.

In 1969 alarm about the costs of Medicare resulted in severe restrictions in coverage for home health services, even though these accounted for only about 1% of Medicare expenditures. Recent uncertainties about the funding of Medicaid certainly have been less than reassuring.

Now we are apparently on the eve of launching some kind of national health insurance program in which home health services are to be considered as merely peripheral. Too little knowledge is avail-

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able. I know of no substantial experimentation that has been done in providing an array of services necessary to meet the very real needs of people outside of institutions and on a broad community basis. A necessary sequel, then, is continued inappropriate use of our most expensive facilities and continued large gaps in relief of misery for the sick at home.

What would a truly sound home health program consist of? The main features might be these:

1) Services should be available through a single port of entry—for the poor and the rich—regardless of health or disease condition, or source of medical care.

2) Access to home care should be based on the legitimate need for health services which are appropriately given at home—the amount and variety of services being determined by the individual situation.

3) This community-based agency should be available for referral from any source—hospitals, nursing homes, clinics, private doctors, social agencies, schools, family, or friends.

4) The *basic services* should be:

   a) *Personal care*—using nurses and home health aides in a carefully designed way to provide maximum efficient service at the level of the patient's need. The public health nurse should coordinate all home health care services.

   b) *Social services*—using professional social workers and aides in proper combination. The extent of services should be adapted to avoid duplicating those available elsewhere in the community.

   c) *Physical and speech therapy*—using therapists largely as consultants to nurses and aides. There will be some situations in which direct services by these therapists will be needed.

   d) *Transportation*—for health related needs.

   e) *Housekeeping* and *nutrition* services.

   f) Provision of *equipment*, *supplies*, and *laboratory* services.

   g) *Care by physicians in the home*—for those who are best served there. However, relatively few patients would require home visits by physicians if all the foregoing services were available.

Obviously all of these services are to be found in one place or another.

They are rarely if ever available at one agency so that all people in the community can utilize them as a sort of "one-stop shopping" center. Proper articulation with other existing services is needed and can be worked out in various ways so that families do not have to expend time and effort in learning about resources at a time when they are often least able to do so.

In today's complexity of arrangements, even when no economic barriers exist in obtaining what one needs, a well person must have great stamina and determination to cope with the maze. The less husky often have to give up short of the goal.

Home care is not cheap, unless you provide no services. The health needs of most people can be met at home, however, for far less cost and effort than in institutions. In total health care costs, it is likely that the omission of home health services is more expensive than its appropriate inclusion in the system would be.

In the context of this discussion, I am assuming that financing home health services as outlined here would come through national health insurance mechanisms. Let it be noted that community nursing agencies have about a century of experience in providing service to people on all economic levels, in working with multiple sources of funding, in cost analysis and, perhaps most useful of all, in economy of procedure during lean times. Lean times have been frequent. Often we have had no opportunity to acquire expanded services or extended geographic coverage.

What can broadened home health services mean to a community? A few examples may be useful:

1) We should be able to provide quickly, and on an emergency basis, supportive services to the mother who comes home with a new baby and who cannot cope with her situation. Given clues such as anxiety, fatigue, depression, or physical complications, a home health aide assigned even for two hours daily for three or four days could relieve the pressure sufficiently for the mother to regain her equilibrium. This is a small investment for a large return in the physical and mental health of a family, but one for which we rarely have the resources today.

2) Probably all of you know of young adults with severely handicapping conditions who are kept in institutions for lack of adequate supportive services at home. Months and indeed years of such institu-

tional care could often be avoided if housekeeping and shopping help were available, along with surveillance of physical condition.

3) Lack of transportation to medical facilities when needed is often a complete barrier to home care for these individuals. Consider now the older person who has a cardiac problem. He may be seen in an emergency room, treated for the immediate problem, sent home, and told to return to a clinic another day. *If* he is referred to the visiting nurse for follow-up, she can assist him with personal care and she can guide him in taking his medications. But, if he is unable to tolerate the arduous trip to the clinic and he runs out of medicine, or his condition changes, both patient and nurse are up against it. What a difference it would make if transportation were available, or if a physician made a home visit, and laboratory services could be provided.

It seems appropriate to mention here the importance of rearranging the role of the physician and the nurse in home care. Obviously, physicians can and should go to patients' homes only when their skills are needed there, but this leaves some rather large questions as to who makes that decision. If we can assume that in home health services the nurse in the home on a continuing basis has been prepared to observe and assess the patient's condition, it seems logical that she can make judgments about the need for medical attention. In fact, she has been doing this for years and doctors have depended on her to do it.

A reasonable extension of this role of the nurse is being carried out in a number of settings in which, within understood protocol, the nurse goes into greater depth of physical assessment and adjusts the treatment regimen accordingly. This practice allows for quicker response to changed needs and permits better use of the physician's time for those in greater need of his service. It also saves the patient unnecessary trips to clinics or offices—a severely debilitating experience for many. The extended role of the nurse is effective not only in the homes of individual patients but also in group settings such as housing for the elderly and single-room occupancy dwellings.

Clearly, the broad gamut of home health services is appropriate for people of all ages and not, as often thought, just for the aged and chronically ill. In our country we seem to take it for granted that, if we set up clinics and hospitals where people can come if they are

sick, we have done enough and people will somehow find the care they need. This bears all the logic of one man's comment: "If the Good Lord had wanted us to fly, he'd have given us tickets." In fact, almost all people are in whatever they call home all their lives, carrying with them their health needs and their illnesses except for very short episodes in medical care facilities.

Health professionals and, I fear, our consumers, too, are so hospital-oriented that they focus practically all our resources and our expertness on these institutions. Only recently has ambulatory care begun to get out of the status of a stepchild. The inadequacies of facilities and services for long-term care, both in quantity and quality, are all too familiar.

What we really need is a continuum of health care resources to include preventive services, as well as acute, ambulatory, and long-term-care services. Each of these should be accessible to the total community and there should be mobility from one level to another. Home health care is an important part of such a system. Unless it is developed and nurtured, we shall continue to consign ourselves, providers and consumers alike, to a health care delivery system unsatisfactory on both humane and economic grounds.